Office of Personnel Management

CATASTROPHIC LEAVE BANK PROGRAM

P.O. Box 3278 – Little Rock, AR 72203

Dependent Child Certification

Part I – To be completed by employee.

I hereby certify that ______________________________
Name of Child (print or type)

Social Security Number ____________________ Date of Birth ____________________

☐ Yes ☐ No a. resides in my home at least 50% of the time

☐ Yes ☐ No b. receives at least 50% of support from me

☐ Yes ☐ No c. is a dependent child

☐ Yes ☐ No d. is a dependent on my Arkansas Income Tax

e. if not claimed as a dependent – please explain below:

Arkansas Code 21-4-203 (4) states that "catastrophic illness" means a medical condition of an employee **or of the spouse or parent of the employee or of a child of the employee which may be claimed as a dependent under the Arkansas Income Tax Act of 1929.**

I authorize the Arkansas Individual Income Tax Section to verify that the above listed child is claimed as a dependent on my Arkansas Individual Income Tax Return for the most recent tax year.

Employee Signature ____________________ Social Security Number ____________________

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Employee's Agency, Address, and FAX Date

For verification of dependent status, submit to: Arkansas Individual Income Tax Section, 227 Ledbetter Building, Little Rock, AR 72201 or FAX 682-7691.

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Part II – To be completed by Arkansas Individual Income Tax Section.

I hereby certify that the above listed child ☐ was ☐ was not listed as a dependent child of the employee for the most recent tax year.

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Name and Title, DFA-Revenue-Individual Income Tax Section Date